Commentary

Partnerships for Improving Border Health

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The United States and Mexico share the longest border in the world between a developed and a developing nation. Nearly 65 million people populate the four US and six Mexican border states, and more than 9 million live in the communities along the border.[1] The health of this unique, binational population is of increasing concern to a broader range of persons and institutions on both sides of the border. As participation in the partnership required for successful border health solutions grows, two newer players—health professional organizations and private foundations—must examine their respective and synergistic roles.

What Health Professional Organizations Can Do

Health professional organizations in the United States, particularly the medical associations of the states at the border, have not ignored the health needs of the border populations. But health professional organizations and their members as individuals can also use their skills to promote health by working to protect the health and human rights of all persons in their localities.

Human rights are divided into civil and political rights, which in our society take priority, and social, economic, and cultural rights, which take second place. Our country subscribes to the belief that without civil and political rights, no other rights, such as the right to health care, can be upheld. This view is not completely shared by other countries or by our own population. For example, public opinion polls have shown that 90% of Americans support health services for all children.[2] The growth of homelessness in the United States is another example of a violation of a basic human right. All human rights need to be honored—not some at the expense of others.

The human rights of many people are being violated in different ways on both sides of the border, and these violations have repercussions for health. Undocumented aliens cross to the United States in large numbers and at times with great risk. Many come not only for social and economic reasons but also for political reasons. Often they are refugees from repression and civil wars in Central and South America. Once in this country, for many the establishment of refugee status is the only way to survive, for repatriation means detention, torture, and even death. In addition, while held in camps, refugees' multitude of health problems may be poorly attended to and, all too often, children who are on their own are held in adult facilities without appropriate services.

The border has been plagued by increasing rates of violence, and the results of rape and brutality eventually come to emergency services. There are also accusations of violence committed by the border patrols; the American Friends Service Committee documented 380 cases of human rights abuses by border patrol agents against immigrants in 1989.[3] There is a growing climate of intolerance of Hispanics in the United States, and there is serious concern about the violation of human rights of Mexicans living here. This climate inevitably leads to rising levels of violence and therefore of serious injury and even death. Thus, attention to human rights needs to be increased in the border area, and health professionals have an important role.

Many health professional organizations have formed human rights committees. These committees usually have started in the international sections of their organizations. They have worked on civil and political abuses of patients or of health professionals themselves. So, for example, the American Academy of Pediatrics has worked to educate its members on violations of the human rights of children and the role that the American Academy of Pediatrics can play toward increasing support for the United Nations Convention on the Rights of the Child.

State medical associations can, through educational activities, meetings, publications, and site visits, increase the visibility of the plight of refugees. They can collaborate with lawyers' human rights organizations on documenting physical abuse that would help to establish refugee status. They also can establish networks of physicians who are willing to learn about and treat persons who have been victims of torture or extreme deprivation and who now reside within their communities. Recognizing a history of abuse in a patient seeking treatment for headache or insomnia, for example, requires an awareness of the political situation in the country of origin and of the possibility of a history of torture. The ability to elicit such a history without harming the patient needs to be developed.

It is not necessary to go to other countries or to go far afield to become more active in the support of human rights of people who have sought refuge from countries where basic human rights are not observed, including, for example, Guatemala and El Salvador. For instance, women who are detained for political reasons are commonly raped. Treating these women refugees is difficult, long term, and essential, and gynecologists and mental health professionals need to collaborate in this endeavor.

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Passive bystanders—whether local or at a distance—allow atrocities to occur through their lack of protest, which is taken as evidence of agreement by the perpetrators. On the other hand, the power of a collective voice on behalf of human rights and the ethical practice of medicine is great. A network of colleagues provides not only people to do the work but also emotional support and confirmation of the value of human rights work.

Health professional organizations can work toward improving the health of the border populations by establishing the right to health care and enforcing that right through universal access to care. Lobbying for effective federal legislation to guarantee health care as a right is an important role for health professional organizations. Securing the right to health care is not enough, however. In Mexico, all citizens have a legislated right to health care, although appropriate care is not universally available. While the Mexican health care system has a comprehensive infrastructure dedicated to serving the uninsured, resources often are inadequate to meet the need for services. Health professional organizations can become powerful voices for action at all levels of government and for promoting binational collaboration to improve access to quality care on both sides of the border. We have much to learn from each other.

What Foundations Can Do

The current configuration of institutions and individuals located at the border or with interest in border health is complex and congested. Public—local, state, and national—and private health care professionals on both sides abound in some areas and are scarce in others. The face of industry and business continues to grow and change; the dramatic proliferation of *maquiladora* ("assembly") plants in northern Mexico exemplifies this transition. The impending free trade agreement will have a substantial effect on health-related concerns, such as environmental and occupational hazards. Academic centers, including colleges and universities, on both sides are an important force. International agencies, such as the Pan American Health Organization and the United States-Mexico Border Health Association, provide some umbrella mechanisms. Each has its own agenda and perspective, its own political and cultural vantage points, and its own perception of "border." All generally agree that there are many problems in health, and most agree that these problems are worsening.

Several questions emerge:

- Is there a unique role that foundations can play amidst this complex configuration?
- Where can and should large foundations fit in this landscape? Is the role any different at the United States-Mexico border from other areas of the country or the region? and,
- Should expectations of national, state, or local foundations or the boundaries within which they normally operate be relaxed or changed to accommodate special conditions at the border?

Health problems at the US-Mexico border have reached crisis proportions. In the United States money coming from state and federal sources is insufficient and unlikely to increase. The greatest share of the burden for the cost of providing health services must inevitably fall on the public sector. Secretary of Health and Human Services (HHS) Louis Sullivan's challenge of the 1990s is serving all Americans. A major goal of HHS for the year 2000 is to decrease the disparities in health between majority and minority populations. Unfortunately, the emphasis is on personal responsibility for health, without a commitment of federal resources sufficient to enable disadvantaged persons to assume such responsibility.

While HHS admits the need to change the environment of the neediest people to improve their health, the burden of change is placed on states and communities. No foundation or even a consortium of foundations has sufficient funds to deliver health services for the long term. Through public and private partnerships, formal and informal, it is possible to enhance greatly what the public sector is able to do, however. Collaboration and cooperation among public and private groups is key to effecting change in the US-Mexico border region.

National foundations do have important roles to play at the border. Foundations are free of the constraints of government and represent only themselves. In the international scope of US-Mexico border activities, foundations are more independent than other umbrella groups such as the Pan American Health Organization or the US-Mexico Border Health Association. This injects an evenness in the complex configuration that keeps the interest of improving health above the fray. Moreover, there are few health umbrella groups, so foundation involvement can facilitate "big picture" approaches and the building of bridges between groups and sectors. Further, in the international arena, some foundations are well known and give credibility to the activities and institutions supported.

Larger foundations or consortia of foundations usually can direct sizable amounts of money at a focused effort (such as research), something that is beyond the scope or capacity of most other regional players, which often provide only leverage money. Foundations can also provide some financial support for infrastructure development. For example, in the initial phase, the Mexican Foundation for Health used private foundation dollars from the United States to support the basic growth and development of the foundation itself, which in turn has led to many other sources of funding and more self-sufficiency. This could be a model for other foundations.

A foundation can promote a particular health agenda such as maternal and child health or the health of women working in *maquilas* and insure its priority amid changing conditions and circumstances. Foundations can have a convening function to link policy, research, and practitioner communities. These meetings can be important to bring other activities to fruition or to produce new ideas. They also help develop policy and identify research needs. Foundations can publicize and disseminate ideas and findings and can stimulate public and private sectors to increase efforts in a particular direction.

The work of national foundations concerned about health in the border region can be enhanced through cooperative relations with nongovernmental community organizations and medical societies. Traditional public health interventions supported by foundations often are channeled through public-sector institutions where support and participation are usually forthcoming. Many families who live on both sides of the border rely on private practitioners for health care, however. Medical societies can provide access to private physicians to solicit and engage their interest, ideas, and participation.

Medical societies also can provide the political will necessary to launch community-based interventions supported by foundation funds. In turn, foundations can augment the work of professional medical societies. Limited financial support for new initiatives to improve health is one option. But more important, foundations can contribute to the work of medical societies by acting as catalysts for change through the promotion of increased physician awareness about the special needs and circumstances of the US-Mexico border population.

Building Partnerships—Linking Foundations and Health Professionals

Foundations and health professional organizations can join forces to improve health. Although each foundation has its own rules and guidelines, events can influence the creation of new programs. Thus, a health crisis along the border may be used to mobilize foundation support at the local, state, and national levels and to create new funding partnerships. Fiscal marriages can ground a project nicely.

Some of the large national foundations have expressed an interest in global environmental issues. It might be possible to capture this interest for the particular environmental needs along the border. Some foundations operate only within states or communities. The Foundation Center, with offices in New York City and Washington, DC, has directories of foundations by geographic area and a listing of foundations that have given grants in health. The Foundation Center can assist those who would like to identify sources of support for research, communication, and other health-related agendas along the border.

Whether publicly or privately funded, health research should be undertaken only if the results are used to benefit and strengthen the study population and mechanisms are built in to implement those parts of the project that work well. Otherwise, demonstration and research projects to improve health will raise community expectations, only to dash them when the project is over. From past experience, it is clear that there should be the same expectations of process and product and of monitoring and evaluating at the border as elsewhere. More attention should be paid to providing technical assistance for development of proposals and projects. There is also a need for binational cultural and language sensitivity compatible with these goals and with the quality of the work.

Medical societies' access to private physicians can be used to raise the awareness of physicians of issues such as health and human rights at the border, or to reach policymakers on border health care issues. The societies can also gain the support of private physicians for particular demonstration or research projects to promote health. With respect to health at the border, medical societies' efforts can help physicians to pay particular attention to specific problems, to think more broadly, and to join with other sectors in efforts to improve health.

If the health and well-being of the millions of families and children living on the border of the United States and Mexico are to improve, basic human rights, including health, must be respected and protected. Key persons and institutions from the private sector must both acknowledge existing or increasing health problems and be a part of creative, multifaceted solutions. Health professional organizations and private foundations, separately and together, can play important roles in fostering change towards health as well as human rights in this unique and increasingly important geopolitical region.

REFERENCES

1. Pan American Health Organization: Annual Report of Activities, 1990—PAHO Field Office United States-Mexico Border, El Paso, Texas, 1991

2. Harris L: Speech, Citizens Committee for Children, Annual Meeting, New York, New York, 1987

3. Briefing Paper: The United States-Mexico Bilateral Agenda: An Overview of Independence. Washington, DC, Overseas Development Council, 1990